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Blaming Culture Perceptions and Nurses' Attitudes in Reporting Medication Error Incidents in Hospital

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Abstract

Background: Patient safety is an important issue for every country that provides health services, regardless of health services using private or government funding methods. **Purpose:** This research aims to determine the relationship between perceptions of blaming culture and Nurses' Attitudes in Reporting Medication Error Incidents at Tongas Regional Hospital, Probolinggo. **Methods:** This research uses a correlational analytical design with a cross-sectional approach. A sample amount 61 respondents obtained using a purposive sampling technique. The instrument used was the blaming culture perception questionnaire adapted from HSOPC, developed by AHRQ 2016. Meanwhile, the nurse attitude questionnaire in reporting medication error incidents had gone through the validity and reliability testing stage with Cronbach's alpha value was 0.876 by previous researchers, and the analytical test used in this research was the Spearman rho test. **Results:** The Spearman's rho analysis test shows a value of α<0.05, namely (0.000) which means that there is a relationship between the perception of Blaming Culture and the attitude of nurses in reporting medication error incidents at the Tongas Regional Hospital, Probolinggo. **Conclusion:** Professionalism and strong work culture must be emphasized through standard work behavior, forming solid teamwork, good communication in the work environment, and the involvement of management in taking the initiative to provide ongoing training and motivation to create awareness of the importance of patient safety culture.

Keywords: Perception of blaming culture, Nurse attitudes, Medication errors

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1. BACKGROUND

Patient safety is an important issue for every country that provides health services, regardless of whether health services use private or government funding methods (WHO, 2011). Standards for patient safety refer to IPSG 1 (International Patient Safety Goals) which discusses medication errors, and patient safety and

IPSG is mandatory in a hospital to obtain quality health services (Setiyajati, 2014).

According to research conducted by Solagracia (2017), around 48,000 - 100,000 patients die due to medication administration errors in the United States. Meanwhile in Indonesia, the National Map of Hospital Patient Safety Incidents report shows that two errors in administering medication were ranked first (24.8%) of the top ten reported incidents. Meanwhile, Salmani (2016) found that errors with a high incidence in non-injection treatment were wrong medication (7.9%), wrong patient (1.6%), and administering medication without a doctor's request (1.6%). In contrast, injection treatment includes wrong infusion (9.5%), wrong dose (7.9%), and wrong drug calculation (6.4%).

According to KKPRS (2015), those who report patient safety incidents are anyone or all hospital staff who first discover the incident and are ready or all staff involved in the incident/incident. Nurses are registered personnel who meet the requirements and are competent to independently practice nursing comprehensively in the manner and level determined and assume responsibility and accountability for nursing practice (Mjadu & Jarvis, 2018). Health workers at the scene if an incident occurs are to immediately provide assistance and make a report to their immediate superior a maximum of 1 x 24 hours after the incident (Tristantia, 2018).

Reporting medication errors is a fundamental effective action that needs to be taken to avoid errors that can harm patients (Ehsani et al, 2013). Evaluation of medication error incidents needs to be carried out by the hospital in order to improve or increase the quality of health services (Kim et al, 2014).

Several factors influence the low level of incident reporting, namely: (1) fear of being blamed (blame culture), (2) lack of commitment from management and related units, (3) no reward from the hospital for reporting, (4) not knowing where the limits are. Or what should be reported, (5) socialization of patient safety incidents has not been comprehensive to all staff, (6) training on patient safety has not been completed for all hospital staff (Iskandar et al, 2014)

Based on a preliminary study at Tongas Probolinggo Regional Hospital, the number of IKP reports in 2022 will be 26 cases. The number of reported patient safety incidents related to medication errors was 10 out of the total reported cases. The 10 KNC cases include errors in administering drug labels, writing unclear prescriptions, writing prescriptions not

accompanied by the patient's name and medical record numbers, and writing drug doses that must be double-checked. Based on the results of interviews with 11 nurses in the Orchid Room. 6 out of 11 nurses said there was still a feeling of fear of being blamed when reporting an incident and thought that later discussions in the work environment would not focus on the incident being reported but rather focus on who reported or committed the error.

The solution that can be done is the need to evaluate the understanding and awareness of hospital staff regarding the importance of reporting medication error incidents in order to create a good safety culture so that the quality of health services provided is quality, sustainable and becomes a learning process for improving services that are oriented towards patient safety.

Based on the description above, researchers are interested in conducting research that aims to analyze the relationship between Blaming Culture perceptions and nurses' attitudes in reporting medication error incidents.

2. METHODS

This research uses a correlational analytical design with a cross-sectional approach, with a sample of 61 nurse as respondents who works in the inpatient room at Tongas Hospital, Probolinggo that obtain using a purposive sampling technique. The criteria in this study were that nurses who worked in the inpatient room at Tongas Probolinggo Regional Hospital had never attended patient safety training. The research instrument used was a blaming culture perception questionnaire adapted from HSOPC developed by AHRQ 2016, which obtained validity test results with a value of >r 0.300 with a valid conclusion. Meanwhile, the nurse attitude questionnaire in reporting medication error incidents had gone through the validity and reliability testing stage with Cronbach's alpha value of 0.876 by previous researchers, and the analytical test used in this research was the Spearman rho test.

This research was conducted with the approval of the STIKES Hafshawaty Research Ethics (approval number: KEPK/126/STIKes-HPZH/V/2023).
Subjects were informed that participation was voluntary; that they were not obliged to respond to items they did not want to answer; and that there would be no disadvantage or negative impact on their work due to interruption or nonparticipation. We asked the subjects to respond to the questionnaire

anonymously, so that they could not be identified by their personal information. There were no conflicts of interest in this study.

3. RESULTS

Characteristics of Respondents

The general data displayed consists of the respondent's age, gender, education, and length of work.

Table 1. Characteristics of respondents at Tongas Hospital Probolinggo in 2023 (N=61)

Characteristics	Frequency	Percentage (%)
Age		
20-30 years	14	23.0
› 30 years	47	77.0
Gender		
Male	20	32.8
Female	41	67.2
Education levels		
Diploma	37	60.7
Bachelor	24	39.3
Length of working		
‹5 years	14	23.0
› 5 years	47	77.0

From the results of Table 1, based on the age it can be seen that the majority of respondents at Tongas Regional Hospital, Probolinggo, were aged ›30 years, 47 respondents (77%). Based on gender, most respondents at Tongas Regional Hospital, Probolinggo, were female, with 41 respondents (67.2%). Based on the education levels, the majority of respondents at Tongas Regional Hospital, Probolinggo, had a Diploma level education, 37 respondents (60.7%). Based on the length of work, the majority of respondents at Tongas Regional Hospital, Probolinggo, have worked for ›5 years, 47 respondents (77%).

Characteristics of Blaming Culture Perceptions

The specific data in this research are the characteristics of blaming culture Perceptions and the characteristics of Nurses' Attitudes in Reporting Medication Error Incidents at Tongas Probolinggo Hospital.

Table 2. Characteristics of Respondents' Blaming Culture Perceptions in Reporting Medication Error Incidents at Tongas Regional Hospital, Probolinggo in 2023 (N=61)

Perception of Blaming Culture	Frequency	Percentage (%)
Low	46	75.4
Moderate	15	24.6
High	0	0

From the results of Table 2, show that the majority of respondents at Tongas Regional Hospital, Probolinggo, had a low category of blaming culture Perception, 46 respondents (75.4%).

Table 3. Characteristics of Nurses' Attitudes in Reporting Medication Error Incidents at Tongas Regional Hospital, Probolinggo in 2023 (N=61)

Nurse's Attitude	Frequency	Percentage (%)
Good	49	80.3
Enough	12	19.7
Low	0	0

From the results of Table 3, it can be seen that the majority of respondents at Tongas Hospital, Probolinggo, had a good attitude, 49 respondents (80.3%).

Table 4. Data Analysis Based on Blaming Culture Perceptions and Nurses' Attitudes in Reporting Medication Error Incidents at Tongas Probolinggo Hospital

Perception of Blaming Culture	Nurse's Attitude			Total
	Good	Enough	Low	
Low	46	0	0	46
	75.4%	.0%	.0%	75.4%
Moderate	3	12	0	15
	4.9%	19.7%	.0%	24.6%
High	0	0	0	0
	0%	0%	.0%	.0%
Total	49	12	0	61
	80.3%	19.7%	.0%	100.0%

From the results of cross table 4, it was found that most respondents at Tongas Hospital, Probolinggo, had a low category of Blaming Culture Perception and a good category attitude, 46 respondents (75.4%).

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Table 5. Spearman Rank Test Results of the Relationship between Blaming Culture Perceptions and Nurses' Attitudes in Reporting Medication Error Incidents at Tongas Regional Hospital, Probolinggo.

Correlations

			Perception of Blaming Culture	Nurse's Attitude
Spearman's rho	Perception of Blaming Culture	Correlation Coefficient	1.000	.867**
		Sig. (2-tailed)	.	.000
		N	61	61
	Nurse's Attitude	Correlation Coefficient	.867**	1.000
		Sig. (2-tailed)	.000	.
		N	61	61

***. Correlation is significant at the 0.01 level (2-tailed).*

The results of the Spearman's rho analysis test show a value of α‹0.05, namely (0.000), which means that there is a relationship between the perception of Blaming Culture and the attitude of nurses in reporting medication error incidents at the Tongas Regional Hospital, Probolinggo. The Correlation Coefficient value shows the number (+0.867), which means that the perception of blaming culture strongly correlates with Nurses' Attitudes in Reporting Medication Error Incidents. A positive value indicates that the lower the blaming culture perception, the better the Nurse's Attitude in Reporting Medication Error Incidents at Tongas Probolinggo Regional Hospital.

4. DISCUSSION

The research results showed that the majority of Tongas Regional Hospital nurses had a perception of blaming culture in the low category, as many as 46 respondents (75.4%), and in the medium category, as many as 15 respondents (24.6%). Most Tongas Regional Hospital nurses had an attitude in the good category, with 49 respondents (80.3%) and 12 respondents (19.7%) in the fair category. The results of the Spearman's rho analysis test show a value of α‹0.05, namely (0.000), which means that there is a relationship between the perception of Blaming Culture and the attitude of nurses in reporting medication error incidents at the Tongas Regional Hospital, Probolinggo.

Identifying Blaming Culture Perceptions in Reporting Medication Error Incidents at Tongas Probolinggo Hospital.

From the results of Table 5.5, it can be seen that the majority of respondents at Tongas Regional Hospital, Probolinggo, had a perception of Blaming Culture in the low category of 46 respondents (75.4%), the medium category of 15 respondents (24.6%) and the high category of 0 respondents (0 %).

Everyone has their own perception of what they think, see, and feel. This also means that perception determines what a person will do to fulfill various interests for themselves, their family, and the community environment in which they interact. This perception is what differentiates one person from another. Perception results from the concretization of thoughts, which gives rise to different concepts or ideas for each person even though the object being seen is the same (Rahmadani, 2020).

Blame or shame culture, which we know as blame culture, requires individuals to perform perfectly and take full responsibility for their performance. Individuals who make mistakes will focus on their weaknesses, hurting their comfort at work, missed opportunities to learn and implement changes, and decreased incident reports for individuals and teams (Robertson, 2018).

A safe patient safety culture in health facilities can be achieved with excellent performance through education, professionalism, and appropriate safety precautions. Building and implementing a safe patient safety culture can be achieved with transparency and applying intelligent transparency to change within the culture. A true learning culture must come from commitment first. Blaming failures in providing care is not a good solution. What often happens when there is a mistake is that individuals immediately rush to blame and ask for responsibility. Learning can be enhanced by viewing errors as opportunities for broader and clearer learning such as errors occurring in the operating room to improve teamwork and communication to discuss the best solution for the patient. The attitude of blaming each other is not a solution to reduce errors, because of this we need a new mindset to improve the quality of providing services and reduce harm to patients (Parker, 2020).

Researchers believe these results indicate a tendency for a relatively low perception of "blaming culture" among Tongas Probolinggo Regional Hospital respondents. The number of respondents

in the low category was 75.4%, indicating that most nurses at Tongas Hospital Probolinggo had a more positive perception regarding the culture of blame and reporting. Although some respondents (24.6%) are in the medium category, this figure also shows that they do not have a very high perception regarding "blaming culture". These results indicate a potential risk of developing a perception of blaming culture from medium to high. The researcher believes this is caused by a lack of emphasis on professionalism and strong work culture through standards of work behavior, lack of solid teamwork, poor communication in the work environment, and important role involvement. Management has the initiative to provide continuous training and motivation to create awareness of the importance of patient safety culture and the attitude of reporting when an incident occurs to create a better patient safety culture at Tongas Probolinggo Regional Hospital.

Identify Nurses' Attitudes in Reporting Medication Error Incidents at Tongas Probolinggo Hospital.

From the results of Table 3, it can be seen that the majority of respondents at the Tongas Probolinggo Regional Hospital had an attitude in the good category of 49 respondents (80.3%), the fair category of 12 respondents (19.7%) and the bad category of 0 respondents (0 %).

Attitude is a form of evaluation or feeling reaction. A person's attitude towards an object is a feeling of support or partiality (favorable) or not supporting or taking sides (unfavorable) towards that object. Social attitudes are formed from social interactions experienced by individuals. Social interaction means more than just the existence of a social group. In social interaction, other relationships occur, and reciprocal relationships also influence each individual's behavior patterns as a member of society (Litt, 2020).

One strategy in designing a patient safety system is to recognize errors so they can be seen and action taken immediately to correct the effects. Efforts to recognize and report these errors are made through the reporting system. Active failure (an officer who makes a mistake) or in combination with a latent condition will cause an error to occur in the form of a near injury (KNC), KTD, or even an event that causes death or serious injury (sentinel). Stopping at the reporting stage will certainly not improve the quality and safety of patients, what is more important is how to learn from these mistakes so that

solutions can be taken so that the same incident does not happen again (Iskandar, 2014).

A hospital patient safety program is a system where the hospital implements safer patient care, including risk assessment activities, identification, and management of matters related to risk, implementation of solutions to minimize the occurrence of risks, the number of near-miss incidents, reporting, and analysis. Incident, the process of learning from the incident, planning for follow-up to the incident, and strategies for preventing injuries caused by errors resulting from carrying out an action or not taking action that should have been taken (Ministry of Health of the Republic of Indonesia, 2011).

Researchers believe these results indicate a tendency for Tongas Probolinggo Regional Hospital respondents to have a positive attitude regarding reporting medication error incidents. With the majority of respondents 80.3% falling into the good attitude category, this shows that most nurses at Tongas Probolinggo Regional Hospital are aware of the importance of reporting medication error incidents and are prepared to do so. In addition, 19.7% of respondents were in the sufficient attitude category, which shows that they also tend to report incidents, although perhaps with a slightly lower level of preparedness. These results indicate that efforts to increase positive attitudes towards reporting medication error incidents at Tongas Probolinggo Regional Hospital have had a significant impact. However, ongoing efforts are still needed to educate and support nurses to strengthen their positive attitude towards incident reporting, so that patient safety culture can continue to be improved and errors can be minimized.

The Relationship Between Blaming Culture Perceptions and Nurses' Attitudes in Reporting Medication Error Incidents at Tongas Regional Hospital, Probolinggo.

The results of the Spearman's rho analysis test show a value of α<0.05, namely (0.000), which means that there is a relationship between the perception of Blaming Culture and the attitude of nurses in reporting medication error incidents at the Tongas Regional Hospital, Probolinggo. The Correlation Coefficient value shows the number (+0.867), which means that the perception of blaming culture has a strong influence on Nurses' Attitudes in Reporting Medication Error Incidents. A positive value indicates that the lower the blaming culture Perception,

the better the Nurse's Attitude in Reporting Medication Error Incidents at Tongas Probolinggo Regional Hospital.

Patient safety is an important issue for every country that provides health services, regardless of whether health services use private or government funding methods (WHO, 2011). Standards for patient safety refer to IPSG 1 (International Patient Safety Goals) which discusses medication errors, and patient safety and IPSG is mandatory in a hospital to obtain quality health services (Setiyajati, 2014).

According to KKPRS (2015), those who report patient safety incidents are anyone or all hospital staff who first discover the incident/incident and are ready or all staff involved in the incident/incident. Nurses are registered personnel who meet the requirements and are competent to independently practice nursing comprehensively in the manner and level determined and assume responsibility and accountability for nursing practice (Mjadu & Jarvis, 2018). Health workers at the scene if an incident occurs are to immediately provide assistance and make a report to their immediate superior a maximum of 1 x 24 hours after the incident (Tristantia, 2018).

Culture is the most important basis for improving patient safety in health facilities, it consists of attitudes, values, beliefs, and behavior packaged into one implementation. Blame or shame culture, which we know as blame culture, requires individuals to perform perfectly and take full responsibility for their performance. Individuals who make mistakes will focus on their weaknesses, hurting their comfort at work, missed opportunities to learn and implement changes, and decrease incident reports for individuals and teams (Sproll, 2018).

According to the research results of Iskandar et al 2014, one factor that influences the low reporting of patient safety incidents is the fear of being blamed (blame culture), according to the Hospital Patient Safety Committee (2015). Without reporting patient safety incidents, it causes more burdens to be received by individuals, families, and society socially and economically due to deaths and the inability to prevent incidents. The poor quality of health services is not sustainable and does not become a learning process for improving services oriented toward patient safety.

The researcher believes that the results showing a significance value of $\alpha<0.05$ (0.000) confirm that the relationship between the perception of "blaming culture" and the attitude of nurses

in reporting medication error incidents at Tongas Probolinggo Regional Hospital is not just a coincidence, but has a clear and real existence. These results indicate a strong correlation between the perception of "blaming culture" and nurses' attitudes in reporting medication error incidents. This shows the importance of paying attention to nurses' perceptions of error culture and how this may influence their attitudes regarding incident reporting. These findings emphasize the importance of reducing the "blaming culture" and encouraging a better safety culture at Tongas Probolinggo Regional Hospital to improve reporting of medication error incidents and overall patient safety.

5. CONCLUSION

The perception of blaming culture influences nurses' attitudes in reporting medication error incidents. The lower the perception of blaming culture, the better the nurse's attitude in reporting medication error incidents, conversely, the higher the perception of blaming culture, the worse the nurse's attitude in reporting medication error incidents. Therefore, professionalism and strong work culture must be emphasized through standard work behavior, forming solid teamwork, good communication in the work environment, and the involvement of management in taking the initiative to provide ongoing training and motivation to create awareness of the importance of culture in patient safety.

AUTHOR CONTRIBUTIONS

Substantial contributions to conceptualization, data curation, analysis and manuscript revisions: Sulastri. Supervision, review and editing: Ainul Yaqin Salam and Zainal Abidin.

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CONFLICT OF INTEREST

The authors declare no conflict of interest for this publication.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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